

Letters

Medical involvement in torture

SIR

Regarding the debate surrounding medical involvement in torture and the articles by Professors R S Downie and R M Hare (1): We have learned from Ayn Rand that when a discussion gets bogged down, one should check one's premises. First, let me offer my definition of *torture*. To torture is to inflict suffering on another to alter his or her mindset. One should comment parenthetically that the word *torture* is used at times to emphasize the severity of inflicted suffering, but this is a borrowed sense. The essence of the meaning is contained in the definition above.

In their articles, Professors Downie and Hare recognize in an inchoate manner that doctoring is *special*. I should like to propose that the distinction is not in the person but in *the contract*. The Hippocratic oath is the contract between the doctor and his patient '... to serve to the best of my ability' in return for payment. This is a special case of contract *between free men*. The law of contract is enshrined in our free society in the English common law and in the American Constitution. The doctor is serving his patient to the best of his ability. The essence of a man is his independent mind. It becomes evident, as a tautology, that torture can never be inflicted within the terms of this contract. So, what of the scenario Professor Hare offers us of a terrorist who has put a bomb in a litter-bin in a crowded place? This is a special case where the duty of the government is to protect the public. A doctor in the service of the state, and being an agent of the state, might be called upon to be associated in the torture of the terrorist in this scenario. Should the doctor plead that because he has a degree in medicine he is too pure to share in what is

essentially a military operation for the well-being of society? Does the term *doctor* confer upon us the hypocrisy of a conscientious objector when one's country is at war? No. I propose to you that a doctor working for the state is in no way superior or purer than any other agent of government. The veterinarian servicing the farmer's herd can help his patients because the health of the animal *usually coincides* with the needs of the farmer. The line of authority runs, however, from farmer through veterinarian. In *the platonic* role a doctor who is a government employee acts; the line of authority is the same. The confusion arose, therefore, from failure to realize that the unique aspect of doctoring is in *the contract* and not *the person*.

Ayn Rand used the term *package deal* to signal the introduction of a concept into a discussion by implication. This is the situation we are living through in America on a grand scale. The dialectic raging regarding health care is *how to make* all doctors work for the state (the platonic relationship). Unfortunately, we are not hearing any discussion about *whether* they should. Elsewhere in the same issue of your journal in The Hippocratic Contract, J Rosalki (2) makes a similar mistake in implying that a contract can have a unilateral purpose. The morals of our great profession have been predicated on a free contract between patient and doctor. The socialist disruption of this relationship should not be tolerated 'in the spirit of our time' but resisted firmly to resist corruption of doctoring.

References

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- (2) Rosalki J. The Hippocratic contract. *Journal of medical ethics* 1993; 3: 154-156.

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Genetic counselling

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The question of what counts as success in genetic counselling is discussed by Chadwick (1) and Clarke (2). They agree that measuring the effectiveness of genetic counselling by number of termination of pregnancies is inappropriate.

Clarke suggests an alternative outcome measure of workload, but Chadwick regards this as inadequate. She also considers the 'right to choose' (or autonomy) to be an inadequate outcome measure. Autonomy is a process rather than an outcome. It is a means to an end. But what end?

She says that one cannot avoid the question of 'what is the objective of genetic counselling?' It is, she suggests, to give options that may improve the genetic health of individuals, thereby improving the genetic health of the population. This is not eugenics, in that the population result is a by-product of giving choice, albeit a restricted choice, to individuals, rather than a government policy. In order to avoid any possibility of hidden coercion, Chadwick suggests that the objective of genetic health be explicitly stated.

Giving choice is not a neutral activity. It involves giving information, and giving information is of necessity selective. What information is given, and how it is presented, is influenced by certain factors, for example, counsellors' beliefs about the objectives of counselling and how to achieve 'non-directiveness'.

So talk of autonomy or workload does not answer the question of what genetic counselling is aiming to achieve, or what counts as success. These questions need to be answered if patients are to be better informed about the service they are being provided with, as advocated by Chadwick.

Clarke tries to deal with the problem by broadening the remit of genetic counselling beyond information relevant to reproductive choice to diagnosis and support for those with genetic disease, and by broadening the measure of effectiveness beyond workload to include patient and referrer satisfaction. Both are steps in the right direction, but they are not sufficient. First, I will deal with the process of counselling; second, with the outcome, and third with the input.

Effective counselling requires effective communication: giving information that is relevant to patients' concerns in a way that is easily understood. We know something about what issues genetic counsellors address, but less about whether these are the issues of most concern to patients (3). We have little information about the extent to which patients' views are elicited or the extent to which counselling style is 'non-directive'.

In terms of outcome, we know something about what patients recall of what they have been told, but less about what they understand and value of what they have been told (4). We know little about the extent to which counsellors have accurately judged patient concerns or met their needs.

Neither patient nor counsellor comes to the consultation as a blank sheet. Each brings their experience, expectations and beliefs. These will shape the process of the consultation and may be important in understanding the outcome and how it is achieved.

In conclusion, there appears to be a lack of clarity about what counts as success *in principle*. Despite this, we can make progress in answering the question of what counts as success *in practice*. The empirical study of the processes of counselling, and how they relate to a variety of outcome measures, can inform us as to what the *active* ingredients of counselling are. Once this is known, the discussion of which of the active ingredients count as *effective* will be easier.

Any discussion of effectiveness, evaluation or success inevitably raises the question of objectives, which include

value systems. The discussion between Chadwick and Clarke is useful in helping to make this explicit amongst health professionals, as a first step to enabling it to be made explicit to patients. The debate about 'what counts as success in genetic counselling?' would be strengthened by:

- more evidence about the input to, the processes and outcomes of counselling, and the relationships between them, and
- the inclusion of purchasers and users of the service.

References

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- (3) Sorenson J, Swazey J, Scotch N. Reproductive pasts, reproductive futures: genetic counselling and its effectiveness. *Birth defects* [original article series] 1981; 17: 4. New York: Alan R Liss, 1981.
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The ethics of paid versus volunteer blood donation

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I read with interest the recent article by Pablo Rodriguez del Pozo concerning the ethics of payment to blood donors (1). This issue has been debated for decades, not so much from an ethical viewpoint, unfortunately, but usually in connection with disease transmission, economic factors, and/or emotional and political factors (2). Prior to the switch to an all-volunteer blood supply in the United States in the 1970s, ethical

concerns were not a prominent part of the debate to eliminate paid blood donors (2,3). That debate centred on a perceived higher incidence of post-transfusion hepatitis from donors paid for their blood donation. However, the debate was also fuelled by misinterpretation of the available scientific data, political manoeuvring by organizations involved in the collection and sale of blood in the United States, and public hysteria and misperceptions of the issues (2,3). Ethical discussion relative to the monetary payment of blood donors is long overdue.

I agree with del Pozo that an all-volunteer blood donation system is imperfect and room could, perhaps should, be made to allow for paid donation. Allowing paid blood donation in certain well defined circumstances is just now being scientifically restudied in light of better donor-screening methods, education, and infectious-disease testing, and the results are encouraging (4,5). As del Pozo points out, even in an all-volunteer donor system, someone still has to pay for the blood. In the United States, it is not uncommon for blood donors to secure non-monetary benefits for blood donation such as, time off from work, free meals, recognition banquets, and various other free gifts. With increased budgetary constraints facing corporations and businesses many employers will be carefully evaluating the impact of such indirect costs when an employee takes time off work to donate blood. Is it fair to make others (for example, employers) indirectly pay for such a 'volunteer' donation? Would it not be reasonable, at least in certain circumstances, to cultivate a cadre of paid donors? Does monetary payment necessarily negate altruism? Is it fair and equitable continually to ask individuals altruistically and freely to donate their red blood cells, their platelets and their plasma when there are profits generated from the sale of those blood components which are not realized by the donor? In addition, it is time, and appropriate, that the various non-monetary incentives and mechanisms used to recruit and compensate blood donors also underwent ethical scrutiny as part of this debate (5,6).

Currently, one rationalization for those few pockets of paid blood donation activity in the United States is the necessity to prevent shortages. However, shortages continue to occur in many, and sometimes most, parts of the country several times a year.